SECTION IV - CONDITIONS FOR PARTICIPATION

Each individual's plan of care for day program services shall be an individualized, progressive, intense program with short-term goals and provide for careful, frequent assessments of the individual's progress and revisions or updates as indicated and necessary.

The program's ongoing activities for the individuals being served shall be purposeful and carry out the goals established by therapists and other professionals in the individual's overall plan of care.

Each Structured Day Program shall meet the minimum staffing ratio established in Subsection M.5(a) of this Section in order to provide the necessary rehabilitation, retraining and supervision of the individual.

As part of the Structured Day Program, prevocational services, if needed, shall be provided in accordance with the individual's approved plan of care.

Supported employment services may be provided in lieu of or in combination with the Structured Day Program. Supported employment is defined in Subsection M.6 of this Section.

Day programming, in any combination i.e., structured day or supported employment services shall not exceed forty (40) hours each week.

The time spent in another service shall be clearly documented and separated from the time spent in the Structured Day Program and billed as a separate service. For example: If the individual attends the Structured Day Program from 10:00 a.m. until 3:00 p.m. and receives speech therapy from 1:00 pm to

2:00 pm; four (4) hours shall be billed to the Structured Day Program and one (1) hour shall be billed to speech therapy.

6. Supported Employment Services

(a) Provider Agency Qualifications

Participating provider agencies of supported employment services shall be licensed as adult day health care centers, or outpatient rehabilitation facilities or shall be Medicaid certified.

(b) Personnel Qualifications

The minimum service provider qualifications are the same as those set forth in Subsection M.5. of this Section.

In addition, persons with a Bachelor's or Master's degree in rehabilitation counseling may also provide supported employment services.

(c) Service Definition

Supported Employment Services shall be:

(1) Paid employment for persons who:

a. Are unlikely to obtain competitive employment at or above minimum wage; and

b. Need intensive ongoing support to perform in a work setting because of a disability.

(2) Conducted in a variety of settings, particularly in work sites in which persons without disabilities are employed.

(3) Activities needed to sustain paid work by an individual receiving waiver services, including supervision and training; and

(4) Paid when not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. For an individual receiving this service, documentation shall be maintained in his record that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142.

When supported employment services are provided at a work site in which persons without disabilities are employed, payment shall be made only for the supervision and training required as the result of the individual's disabilities, and shall not include payment for the supervisory activities rendered as a normal part of the work setting. This service shall be necessary to prevent institutionalization and to assist the individual in his rehabilitation and re-entry into the community.

Supported employment services shall be provided in lieu of or in combination with the Structured Day Program. One-on-one job coaching shall be provided at the job site either by Day Program staff or by contractual arrangements made by the day program in cooperation with the case manager.

7. Behavior Programming

(a) Provider Agency Qualifications

Participating provider agencies for behavior programming shall be Medicaid-certified.

(b) Personnel Qualifications

A behavior specialist who provides behavior programming services shall be a:

(1) Licensed psychologist;

(2) Certified psychologist with autonomous functioning;

(3) Psychological associate or certified psychologist;

(4) Psychiatrist;

(5) Licensed clinical social worker; or

(6) Clinical nurse specialist with a Master's degree in psychiatric nursing or rehabilitation nursing or an Advanced Registered Nurse Practitioner (ARNP) **AND**

shall have a minimum of one year of experience as a behavior specialist or shall provide documentation of coursework in the principles and techniques of learning and behavior.

Unless otherwise specified, to be qualified to provide services under the ABI Waiver Program, all licensed, certified or degreed professional staff shall, within the prior five (5) years, have two thousand (2000) hours of experience in serving persons with a primary diagnosis of acquired brain injury. This experience shall be in: Primary, direct assessment or treatment of individuals with acquired brain injuries, or

administrative responsibilities for an organized brain injury program.

Successful completion of a sixteen (16) hour approved brain injury orientation and training program for professional staff may be substituted for the required experience in serving persons with a primary diagnosis of acquired brain injury.

All professional staff shall be required to complete six (6) hours of continuing education in brain injury annually.

(c) Service Definition

Behavior Programming entails individually designed strategies to decrease the individual's severe maladaptive behaviors which have interfered with his ability to remain in the community. It includes:

(1) The use of a planned systematic application of techniques and methods to influence or change a behavior in a desired way;

(2) The belief that behavior is learned and maintained because of its consequences;

(3) Techniques to increase acceptable behavior and decrease maladaptive behavior;

(4) Monitoring of the individual's progress and development of any needed revisions to the plan, to be accomplished through an analysis of data about the frequency, intensity, and duration of the behavior and observations of staff working with the individual; Addressing maladaptive behaviors which:

(a) Present a risk of or result in harm to the person or others;

(b) Result in property damage;
(c) Interfere on an on-going basis with the delivery of services identified in the plan of care;
(d) Interfere with the individual's acceptance and reintegration into the community ;or
(e) Are illegal

(5) Development of a structured behavioral intervention plan;
(6) Implementation of the plan;

(7) On-going training and supervision to caregivers and direct contact and service staff; and

(8) Periodic reassessment of the plan.

(9) An approved behavior intervention plan shall be carried out by direct contact and service staff in all relevant environments and activities, under the supervision of the Behavior Specialist. Behavior programming may be provided in the individual's home or in the community.

Behavioral learning principles and techniques are applied to:

Promote acquisition and mastery of adaptive behavioral patterns; and To reduce or eliminate maladaptive behavioral patterns.

A functional analysis shall be completed by a qualified professional behavioral specialist. The functional analysis shall include:

(1) The target behavior;

(2) Frequency, intensity and severity of the behavior;

(3) Antecedents and consequences of the behavior;

(4) An analysis of the potential communicative intent of the behavior;

(5) The history of reinforcement for the behavior;

(6) Environments where the behavior does and does not occur;

(7) The social context;

(8) Hypotheses regarding the motivation, purpose and factors that maintain the behavior;

(9) Medical, physical, cognitive and emotional status of the individual

(10) Knowledge and reaction of significant others involved;

(11) Day to day changes in personal functioning of the individual

(12) A history of other approaches which have proven unsuccessful in changing the behavior

(13) A justification for changing the target behavior

Upon completion of the functional analysis, the behavior specialist may develop a Behavior Intervention Plan in cooperation with the individual. The Behavior Intervention plan shall include, at a minimum:

(1) The target behaviors to be changed;

(2) Procedures for generalizing and maintaining goals in the individual's natural environment;

(3) A history of other approaches which have proven unsuccessful in changing the behavior;

(4) A justification for changing the target behavior; and

(5) Time frames for review, revision and completion

(6) An indication of the frequency, intensity or duration of the target behaviors;

(7) A justification for intervention;

(8) The replacement behaviors to be taught and specification of the methods for teaching them;

(9) The specific methods to be employed to change the target behaviors;

(10) The methods of data collection and evaluation of the effectiveness of the intervention;

(11) The specific reinforcers to be used;

(12) An indication of the rights being restricted;

(13) An indication of the risks of intervention and the risks of the behavior;

(14) Documentation of the informed consent of the individual and his legal representative; and

(15) Documentation of approval by the Behavior Intervention Committee and the Human Rights Committee when restrictive procedures are used.

Upon completion of the functional analysis and the development of an approved comprehensive Behavior Intervention Plan and its implementation, the plan shall be monitored on an on-going basis by the Behavior Specialist for successful outcome.

All Behavior Intervention Plans shall incorporate the least restrictive, least aversive and least intrusive procedures. The dignity and rights of the individual shall always be protected

Individuals who are suicidal, or homicidal or who are acutely psychotic will require other forms of treatment and would not meet the level of care criteria to receive services under the ABI waiver.

Behavior programming services are necessary to avoid institutionalization and to assist the individual in his rehabilitation and re-entry into the community.

8. Counseling

(a) Provider Agency Qualifications

Participating provider agencies for counseling services shall be Medicaid certified.

(b) Personnel Qualifications

Providers of counseling shall be a:

(1) Psychiatrist;

(2) Licensed psychologist;

(3) Certified psychologist with autonomous functioning;

(4) Psychological associate or certified psychologist;

(5) Licensed clinical social worker;

(6) Clinical nurse specialist with a Master's degree in psychiatric nursing or an Advanced Registered Nurse Practitioner (ARNP); or

(7) Certified alcohol and drug counselor.

SECTION IV - CONDITIONS FOR PARTICIPATION

(c) Service Definition

Counseling services under the ABI Waiver Program are designed to help the individual to resolve personal issues or interpersonal problems resulting from the acquired brain injury. Counseling, as an adjunct to behavioral programming may be provided in severe cases, and may include services for substance abuse. If counseling is provided to members of the individual's family, it must be to assist the family in implementing the individual's approved plan of care and for the direct benefit of the individual. Group therapy may be provided if included as a part of the individual's approved plan of care. This service shall be necessary to prevent institutionalization and assist the individual in his rehabilitation and re-entry into the community. Group therapy is a therapeutic intervention provided to a recipient in a group not to exceed eight participants that focuses on subjects relevant to all participants for one or more of the following reasons:

a. Providing substance abuse or chemical dependency treatment;
b. Building and maintaining healthy relations;
c. Developing social skills;
d. Developing skills to cope with and adjust to a brain injury, including the use of cognitive remediation strategies such as the development of compensatory memory and problem solving strategies, and the management of impulsivity; and
e. Increasing knowledge and awareness of the effects of the acquired brain injury.upon participants'

functioning and social interactions.

Group therapy is distinct from structured day program services which offer group activities in a rehabilitative environment that focus on the development and improvement of community living skills, personal and living independence, work adjustment and productivity, and psychological and social adjustment.

Group therapy shall not include physical exercise, recreational, educational, or social activities and shall not be merely diversional in nature.

Group therapy usually occurs for a limited time period, not exceeding ninety (90) minutes and usually occurs not more than once weekly. Group therapy may occur in conjunction with individual counseling. When a recipient participates in both group therapy and individual counseling, the individual counseling usually occurs once weekly for a period not exceeding sixty (60) minutes.

Group therapy may be provided if included as part of the individual's approved plan of care and shall be provided in accordance with a therapeutic goal in the approved plan of care. This service shall be necessary to prevent institutionalization and assist the individual in his rehabilitation and re-entry into the community.

9. Occupational Therapy, Speech Hearing and Language Services

(a) Provider Agency Qualifications
Participating provider agencies shall be Medicaid-certified.

(b) Personnel Qualifications

Providers of Occupational Therapy and Speech, Hearing and Language services shall meet all applicable State licensure and certification requirements and be employed by or under contract with a participating ABI waiver provider agency.

(c) Service Definition

These services shall be provided under the approved Medicaid State Plan. ABI Waiver Program coverage shall be available only for services over and above the Medicaid State Plan limitations in order to provide the services necessary to prevent institutionalization and assist the individual in his rehabilitation and re-entry into the community.

10. Specialized Medical Equipment and Supplies

(a) Provider Agency Qualifications

When prior authorized and included in the approved plan of care, the case management agency shall arrange for and obtain specialized medical equipment and supplies from Medicaid-certified pharmacies and medical suppliers that are certified for participation in the Federal Medicare and Kentucky's Medicaid Programs. (The MAP-95 form is used to request prior authorization of this services.)

(b) Coverage Definition

Medicaid reimbursement under the Acquired Brain Injury Waiver Program shall be limited to specialized medical equipment and supplies. These services shall be preauthorized by the Department for Medicaid Services or its designated agent. Preauthorization shall be based on the medical necessity and the intrinsic essentialness of the equipment and supplies to the rehabilitation and retraining of the individual in accordance with the individual's plan of care.

Life support equipment, ancillary supplies and related equipment shall not be included in ABI waiver service coverage. Individual's dependent upon life support equipment, ancillary supplies and related equipment shall not be considered medically ready to successfully participate in the ABI Waiver.

The equipment and medical supplies shall be specified in the individual's approved plan of care. Coverage under the ABI Waiver Program shall be limited to items over and above the coverage available under the approved Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation. These items shall be necessary to prevent institutionalization and to assist the individual in his rehabilitation and re-entry into the community.

Items which are not medically necessary or of direct medical or remedial benefit to the recipient shall be excluded from coverage.

11. Environmental Modifications

(a) Provider Qualifications

Environmental modifications shall be provided in accordance with applicable state and local building codes.

(b) Personnel Qualifications

When prior authorized and included in the plan of care, the case management agency shall arrange for environmental modifications to be made by qualified contractors. (The MAP-95

form is used to request prior authorization of this service.)

Contractors shall meet all state and local law requirements.

Plumbers shall meet all requirements set forth in KRS Chapter 318 and 815 KAR 20:030.

Electricians shall meet all requirements set forth in KRS Chapter 227 and 815 KAR 35:015.

(c) Service Coverage Definition

Environmental modification coverage shall be limited to those physical adaptations to the individual's home, specified in his approved plan of care, which:

(1) Are necessary to ensure his health, welfare, and safety;

(2) Enable him to function with greater independence in his home without which he would require institutionalization; or

(3) Are necessary to accommodate the medical equipment and supplies required for his welfare.

Vehicle modifications and electronic monitoring systems shall not be covered services under the ABI Waiver Program.

Medicaid reimbursement for environmental modifications shall be no more than $1000 per

six month period per individual.

12. Community Residential Services

(a) Provider Agency Qualifications

Participating provider agencies for community residential services (CRS) shall be Medicaid-certified. Compliance with the requirements for the provision of CRS shall be monitored by the Department for Medicaid Services or its designated agent by annual on-site surveys.

(b) Personnel Qualifications

Persons who provide community residential services shall, as a minimum:

(1) Be required to have a high school diploma or GED;
(2) Be CPR certified;

(3) Be free from communicable diseases;

(4) Have no past criminal record as defined in Subsection G of this Section;

(5) Have no history of perpetrating fraud, abuse, neglect or exploitation; and

(6) Have successfully completed a formalized training program, such as the Nursing Facility Nurse Aide Training or Home Health Aide Training Program or experience of at least two (2) years, full-time, in home health, long term care, acute care hospital or rehabilitation hospital.

The employer agency shall check the Nurse Aide Abuse and Neglect Registry maintained by the Office of the Inspector General, Division of Licensing and Regulation **and** any other applicable registry to determine if the individual has any history of perpetrating abuse or neglect. **NOTE:** Only certified nurse aides employed or previously employed in nursing facilities may be on the Nurse Aide Abuse and Neglect Registry.

The provider agency shall ensure that the community residential services provider is properly trained and capable of meeting the needs of the individual.

In addition, CRS providers shall successfully complete the sixteen (16) hour brain injury orientation and training curriculum approved by the Kentucky Medicaid Program. They shall also complete six (6) hours of continuing education in brain injury annually.

(c) Service Definition

Services which consist of up to 24-hour supervision and oversight, supportive services training in activities of daily living, social skills, and home management tasks provided to residents of a staffed residence or group home.

Supportive services include socialization (part of a plan of care, not diversional or recreational), training individuals to set up meetings and appointments, and providing transportation (when provided by the residential facility only).

SECTION IV - CONDITIONS FOR PARTICIPATION

The CRS provider shall provide assistance and training with personal and home management tasks when the individual is not yet able to perform them independently, including:

(1) Reminding residents to take medications or perform exercises;

(2) Household chores when residents' care requires the prevention of exposure to infectious disease or containment of infectious disease;

(3) Assisting with dressing, oral hygiene, hair care, grooming and bathing;

(4) Housekeeping;

(5) Laundry; and

(6) Shopping

Community residential services shall include the retraining of the individual in the performance of home care and home management tasks in accordance with the individual's plan of care.

CRS services may include:

(1) Supervision and oversight.

(2) Supportive services, such as:

a. Socialization as part of the approved plan of care and not diversional or recreational; and

b. Assisting individuals in arranging meetings and appointments, and providing transportation.

(3) Individualized home care assistance tasks, such as:

a. Preparing modified diets, for example, diabetic or low sodium diets;

b. Reminding individuals to take medications or to perform exercises;

c. Household chores when the individual's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

d. Assisting with dressing, oral hygiene, hair care, grooming and bathing.

(4) Individualized home management tasks, such as:

a. Housekeeping;

b. Laundry;

c. Preparation of regular snacks and meals; and

d. Shopping.

Community residential services may provide up to twenty-four (24) hour services

Individuals not living with a caregiver are eligible to receive community residential

services. Persons currently residing with a caregiver, but who are demonstrating maladaptive behavior that places themselves, their caregivers or others at significant risk of injury or jeopardy are also eligible for CRS if the caregiver is unable to effectively manage the behavior or the risk it presents, resulting in the need for removal from the home to a more structured setting. Persons whose behaviors may result in legal problems if not ameliorated, are eligible for this service.

The purpose of twenty-four (24) hour CRS coverage shall be to allow time to transition the individual into the community and to make alternative arrangements for necessary supervision.

The provider's time spent in the home during the individual's absence shall not be a covered community residential service.

Priority for locating existing alternative living arrangements that will continue to be available to the individual after he or she is no longer receiving waiver services will be given to those individuals for whom, based upon their progress, needs, and abilities, it may be projected that they no longer meet nursing facility level of care within the next six months. The interdisciplinary team, with the involvement of the individual will develop a transition plan that reflects the services and supports the individual will need following discharge from the waiver, the resources available to obtain those services and supports, the plan for obtaining those resources, and who is responsible for obtaining

or assisting the individual in obtaining those resources. It is the case manager's responsibility to ensure that he plan is developed, to ensure that identified services and supports are obtained, and to assist the individual in locating existing alternative living arrangements.

The staffing ratio for CRS services shall not exceed three (3) ABI waiver individuals per one (1) direct service staff person in a staffed residence.

When CRS services are provided in a group home, the staffing ratio for CRS services shall be sufficient to ensure the individual's health, welfare, and safety, and to ensure that the individual's plan of care is implemented.
Community-residential services shall be necessary to prevent institutionalization and to assist the individual in his rehabilitation and re-entry into the community.

Community residential services shall not include the cost of room and board.

SECTION V - ACQUIRED BRAIN INJURY SERVICE COVERAGE REQUIREMENT

V. ACQUIRED BRAIN INJURY WAIVER SERVICE COVERAGE REQUIREMENTS

A. Prior Authorization Procedures

1. The Department for Medicaid Services or its designated agent shall prior authorize all Acquired Brain Injury Waiver Program services to ensure that the:

   (a) Level of care criteria and ABI waiver service eligibility requirements are met;

   (b) ABI waiver services are defined in the approved plan of care;

   (c) Services are medically necessary and of a direct or remedial benefit to prepare the individual for re-entry into the community;

   (d) ABI waiver services prevent institutionalization and prepare the individual to reside in the community without continued ABI waiver services;

   (e) Services are adequate to meet the individual's needs; and

   (f) Cost of services shall not reasonably be expected to exceed the cost of the appropriate level of institutional care.

   Consideration shall be given to the individual's home situation, the caregiver support available, type and amount of service requested, and that NF placement may be recommended without ABI waiver services.

2. The prior authorization process consists of three (3) steps as follows:

SECTION V - ACQUIRED BRAIN INJURY SERVICE COVERAGE REQUIREMENT

(a) The case management agency shall request and obtain by telephone a nursing facility level of care determination.

(b) Upon receipt of the written level of care determination, the ABI Waiver Program case manager shall submit to the PRO the following information to request a determination of the individual's medical eligibility for ABI waiver services:

(1) A copy of the Acquired Brain Injury Plan of Care form (MAP-4097). (At this time the case manager is not required to identify specific providers.)

(2) A completed MAP-4099 form signed and dated by the individual's attending physician recommending the ABI Waiver Program; (NOTE: Signature stamps are not acceptable);

(3) The Kentucky Medicaid Certification Form (MAP-350); and

(4) The Peer Review Organization's (PRO) Certification for Nursing Facility Services Form.

The level of care determination for admission to and continued stay in the ABI waiver program shall be made by the PRO's registered professional nurses, with telephone consultation with a Kentucky-licensed physician if necessary. The consultant physician shall:

(1) Be a physical medicine and rehabilitation physician (physiatrist) or a physician (neurologist, orthopedist, etc.) who is qualified by virtue of his training and experience in

rehabilitation; and

(2) Have two (2) years full-time experience in the management of rehabilitation services in a brain injury program.

(c) The ABI Waiver Program case manager shall submit to the Department for Medicaid Services or its designated agent the following information for approval of the plan of care and ABI waiver service eligibility:

(1) A completed Plan of Care form (MAP-4097);

(2) A copy of the level of care confirmation notice;

(3) A copy of the notification of ABI Waiver Program eligibility from the PRO;

(4) A completed MAP-4099 form signed and dated by the individual's attending physician recommending the ABI Waiver Program;

(5) The Kentucky Medicaid Certification Form (MAP-350); and

(6) A completed "Acquired Brain Injury Waiver Services Program Applicant/Recipient Memorandum of Understanding" (MAP-4096.)

The Department for Medicaid Services or its designated agent shall review the Plan of Care taking into consideration the appropriateness of the plan for services and the cost-effectiveness in providing the services in the community rather than in a nursing facility.

B. Approval

The ABI waiver case management agency that initiates the request

for services for an individual who is subsequently approved for ABI Waiver Program services shall receive written approval from the Department for Medicaid Services or its designated agent. Reimbursement shall not be made for services rendered prior to the authorization of service coverage.

C. Denial

The individual and the ABI waiver case management agency that initiated the request for services shall receive notification when an individual has been denied ABI waiver service coverage.

The individual's hearing and appeal rights are established in accordance with 907 KAR 1:560 and 907 KAR 1:563.

D. Modifications

All modifications of the plan of care shall be prior authorized. The ABI waiver service case management agency shall notify the Department for Medicaid Services or its designated agent of a modification by submitting the following information:

1. An ABI Plan of Care Modification Form (MAP-4098);

2. A MAP-95 if environmental modifications or specialized medical equipment and supplies are requested; and

3. A brief explanation of the need to increase service, extend service, reduce service, or add environmental modifications or specialized medical equipment.

E. Re-evaluation

A re-evaluation shall be conducted at least every six (6) months to determine the individual's continued eligibility for nursing facility level of care and continued ABI waiver coverage.

The case manager shall:

SECTION V - ACQUIRED BRAIN INJURY
SERVICE COVERAGE REQUIREMENT

1. Request and obtain a level of care determination by the PRO at least every six (6) months; and

2. Submit the current level of care confirmation notice along with an updated plan of care to the Department for Medicaid Services or its designated agent.

This information shall be used for the determination of continued ABI waiver eligibility and prior authorization.

F. Terminations

The Department for Medicaid Services or its designated agent and the Department for Community Based Services (DCBS) shall be notified immediately whenever a recipient has been terminated from the ABI Waiver Program. Upon discharge of an individual from the ABI Waiver Program, the individual's case management provider shall complete the first seven (7) blanks of a MAP-24B and submit the MAP-24B to the:

1. The DCBS local office where the family or interested party representing the applicant resides; and

2. Department for Medicaid Services or its designated agent.

The following procedure shall be followed if an individual is receiving ABI Waiver service and is admitted to a rehabilitation facility or a NF:

1. The ABI waiver case management provider shall complete an entire MAP-24B form, and submit one (1) copy of the form to the local DCBS office, and a copy of the form to the Department for Medicaid Services or its designated agent. If an individual receives a temporary discharge from ABI waiver services for not more than sixty (60) days, the MAP-24B form shall so state and the individual is not required to be terminated.

SECTION VI - REIMBURSEMENT

VI. REIMBURSEMENT

Reimbursement under ABI Waiver Program is limited to services provided in accordance with the individual's approved plan of care.

Reimbursement shall be at the lesser of a provider agency's usual and customary charge or the Medicaid fixed upper payment limit. Reimbursement shall not exceed the Medicaid fixed upper payment limit.

Services provided by family members shall not be reimbursed. Providers shall not enter into an employee or contractual arrangement with an individual's family member for the purpose of providing waiver services.

Following are the procedure codes by type of service, unit of service and the Medicaid fixed upper payment limit:

Procedure Code	Community Residential Service	Unit of Service	Fixed Upper Payment Limits
X0100	Group Home	Not Applicable	$90.00
X0101	Staffed Residence	Not Applicable	$200.00

KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY WAIVER SERVICES PROGRAM
PHYSICIAN CERTIFICATION FORM
MAP-4099

MAP-4099

KENTUCKY MEDICAID PROGRAM
ACQUIRED BRAIN INJURY WAIVER
SERVICES PROGRAM
PHYSICIAN CERTIFICATION FORM

TO: _____

AGENCY: _____

ADDRESS: _____

_____ PHONE: _____

PHYSICIAN'S RECOMMENDATION

I recommend the Acquired Brain Injury Waiver Services Program for:

CLIENT: _____

ADDRESS: _____

_____ PHONE: _____

SOCIAL SECURITY #: _____ MAID #: _____

DIAGNOSIS (ES): _____

_____

I certify that if acquired brain injury waiver services were not available, nursing facility placement shall be appropriate for this individual in the near future.

PHYSICIAN'S NAME: _____ UPIN #: _____

ADDRESS: _____

_____ PHONE: _____

_____ _____
SIGNATURE DATE

LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM CERTIFICATION FORM

I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993, states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/BI, ICF/MR/DD), home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services.

Recovery will only be made from an estate if there is no surviving spouse, or children under age 21, or children of any age who are blind or disabled.

I certify that I have read and understand the above information.

_____ _____

Signature Date

II. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested _____; is not requested _____.

_____ _____

Signature Date

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested _____; is not requested _____.

_____ _____

Signature Date

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested _____; is not requested _____.

_____ _____

Signature Date

D. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested _____; is not requested _____.

_____ _____
Signature Date

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____ _____
Signature Date

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_____ _____
Signature Date

V. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

_____

Phone: _____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

_____

Phone: _____

Signature and Title of Person Assisting with Completion of Form:

_____

Agency/Facility: _____

Address: _____

RANCHO SCALE

RANCHO SCALE

LEVEL	RESPONSE
I.	No response Patient is completely unresponsive to any stimulus.
II.	Generalized response Patient reacts to the environment, but not as a specific response to the stimulus - responses are often the same despite change of stimuli. The earliest response is often gross movement to deep pain.
III.	Localized response Patient reacts in a specific manner to the stimulus, but may inconsistently turn head to sound, withdraw an extremity to pain, squeeze fingers placed in the hand, or respond to family members more than others.
IV.	Confused, agitated Patient is in a heightened state of activity, but is still severely detached from the surroundings. Internal confusion and very limited ability to learn is combined with short attention span and easy fatigue. The patient is unable to cooperate and may be aggressive, combative, or incoherent.
V.	Confused, inappropriate/non-agitated Patient appears alert and is able to respond to simple commands. Responses are best with familiar routines, people, and structured situations. Distractibility and short attention span lead to difficulty learning new tasks and agitation in response to frustrations. If physically mobile, there may be wandering. Much external structure is needed. Initiation and memory are limited.
VI.	Confused, appropriate Patient shows goal-directed behavior, but still is dependent on external structure and direction. Simple directions are followed consistently and there is carry-over of relearned skills (like dressing), yet new learning progresses very slowly with little carry-over. Orientation is better and there is no longer inappropriate wandering.
VII.	Automatic, appropriate Patient appears appropriate and oriented within familiar settings such as home and hospital, but is confused and often helpless in unfamiliar surroundings. The daily routine can be managed with minimal confusion as long as there are no changes. There is little recall of what has just been done. There is only a superficial understanding of the disability, with lack of insight into the significance of the remaining deficits.

RANCHO SCALE

VII. continued	Judgement is impaired with inability to plan ahead. New learning is slow and minimal supervision is needed. Driving is unsafe; supervision is needed for safety in the community or in school and workshop settings.
VIII.	Purposeful, appropriate Patient may not function as well as before the injury, but is able to function independently in home and community skills, including driving. Alert, oriented, and able to integrate past and present events. Vocational rehabilitation is indicated. Difficulties dealing with stressful or unexpected situations can arise, as there may be a decrease in abstract reasoning, judgement, intellectual ability, and tolerance of stress relative to premorbid capabilities.

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY WAIVER SERVICES PROGRAM
APPLICANT/RECIPIENT MEMORANDUM OF UNDERSTANDING
MAP-4096

MAP - 4096

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY WAIVER SERVICES PROGRAM
APPLICANT/RECIPIENT MEMORANDUM OF UNDERSTANDING

I, _____ (Applicant Name), and/or _____, my legal representative or family member have been informed on _____ (Date) and understand the following:

1. The Medicaid Acquired Brain Injury Waiver Services Program provides temporary part-time assistance to me, _____ (Applicant Name), and others who are involved in my care;

2. The acquired brain injury services are available only so long as my care needs meet the Kentucky Medicaid Program nursing facility level of care requirements which allow Medicaid payment;

3. The provision of services under the Program do not replace services provided by family members and other community resources at no cost to the Medicaid Program;

4. To be Medicaid-reimbursed, acquired brain injury waiver services shall be provided in accordance with the written plan of care developed by health care professionals who are assisting me with my rehabilitation and retraining (the plan of care is developed with my knowledge and input);

5. I and my caregivers are obligated to actively participate and cooperate in all rehabilitation and retraining provided to me by the Acquired Brain Injury Waiver Program as we work toward the common goal of my discharge from the Program; and,

6. I and my caregivers are obligated to actively work together toward a common goal of discharge from the Program.

I and/or my legal representative also acknowledge and accept that I shall be discharged from the Acquired Brain Injury Waiver Services Program:

1. At such time the Department for Medicaid Services, or its designated agent, determines that I no longer meet the nursing facility level of care criteria;

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES
ACQUIRED BRAIN INJURY WAIVER SERVICES PROGRAM
APPLICANT/RECIPIENT MEMORANDUM OF UNDERSTANDING
MAP-4096

2. When it is determined by the Department for Medicaid Services, or its designated agent, that the provision of waiver and other Medicaid-covered services in the community are more expensive than they would be if provided in a nursing facility; and/or,

3. When it is determined by the Department for Medicaid Services, or its designated agent, that I am able to function in the community without acquired brain injury waiver services with the assistance of family, other informal supports and community services that are usually available.

We further understand that my Medicaid financial eligibility could end upon discharge from the Waiver Program, if my eligibility is based on the special income provision of the Acquired Brain Injury Waiver Services Program or spend-down.

I have been informed of my appeal rights under the Acquired Brain Injury Waiver Services Program.

Recipient/Applicant	Legal Counsel (If Applicable)	Date
Family Member	Relationship	Date
Legal Representative	Title	Date
Case Manager/Witness	Employer Agency	Date

HOME AND COMMUNITY-BASED SERVICES PROGRAM
ACQUIRED BRAIN INJURY
PLAN OF CARE
MAP-4097

MAP-4097

HOME AND COMMUNITY-BASED SERVICES PROGRAM

ACQUIRED BRAIN INJURY

PLAN OF CARE

Recipient Information: Anticipated Length of Stay: _____

Name: _____ Medicaid #: _____

Current Living Arrangement: _____ Own Home _____ Personal Care Home

_____ Group Home _____ Family Care Home

_____ Alternative Living Arrangement _____ Community Residential Services

_____ Other, please specify: _____

Name of Facility if other than own home: _____

Address: _____ Level of Care Dates: _____

_____ _____

_____ Date of Birth: _____

Rancho Scale: _____

Case Manager: _____ Telephone: _____

Agency Name and Provider Number: _____

Address: _____

_____

_____

Diagnosis/Condition that is focus of treatment: _____

_____

_____

Onset/Date of Injury: _____

Circumstances/Cause of Injury: _____

_____

HOME AND COMMUNITY-BASED SERVICES PROGRAM
ACQUIRED BRAIN INJURY
PLAN OF CARE
MAP-4097

Summary of Neurological Findings and Impressions
Cognitive/Motor/Sensory/Visual Functioning - Abilities/Impairments: _____

Communication (Speech/Hearing) Skills/Limitations: _____

Summary of Past Medical History and Current Medical Status: _____

Current Medications (Include Name, Dosage, Frequency and Purpose):

Allergies: _____

Physical Challenges/Accommodations (Address all limitations such as self care and mobility): _____

Inappropriate/Maladaptive Behaviors that are a focus of concern: _____

Summary of Secondary Mental Health or Substance Abuse Disorders (Specify Axis I or Axis II Condition if applicable): _____

HOME AND COMMUNITY-BASED SERVICES PROGRAM
ACQUIRED BRAIN INJURY
PLAN OF CARE
MAP-4097

Identified Mental Health Treatment Needs (if applicable): _____

Vocational Issues (if applicable): _____

Identified Safety Issues Related to ALL Areas: _____

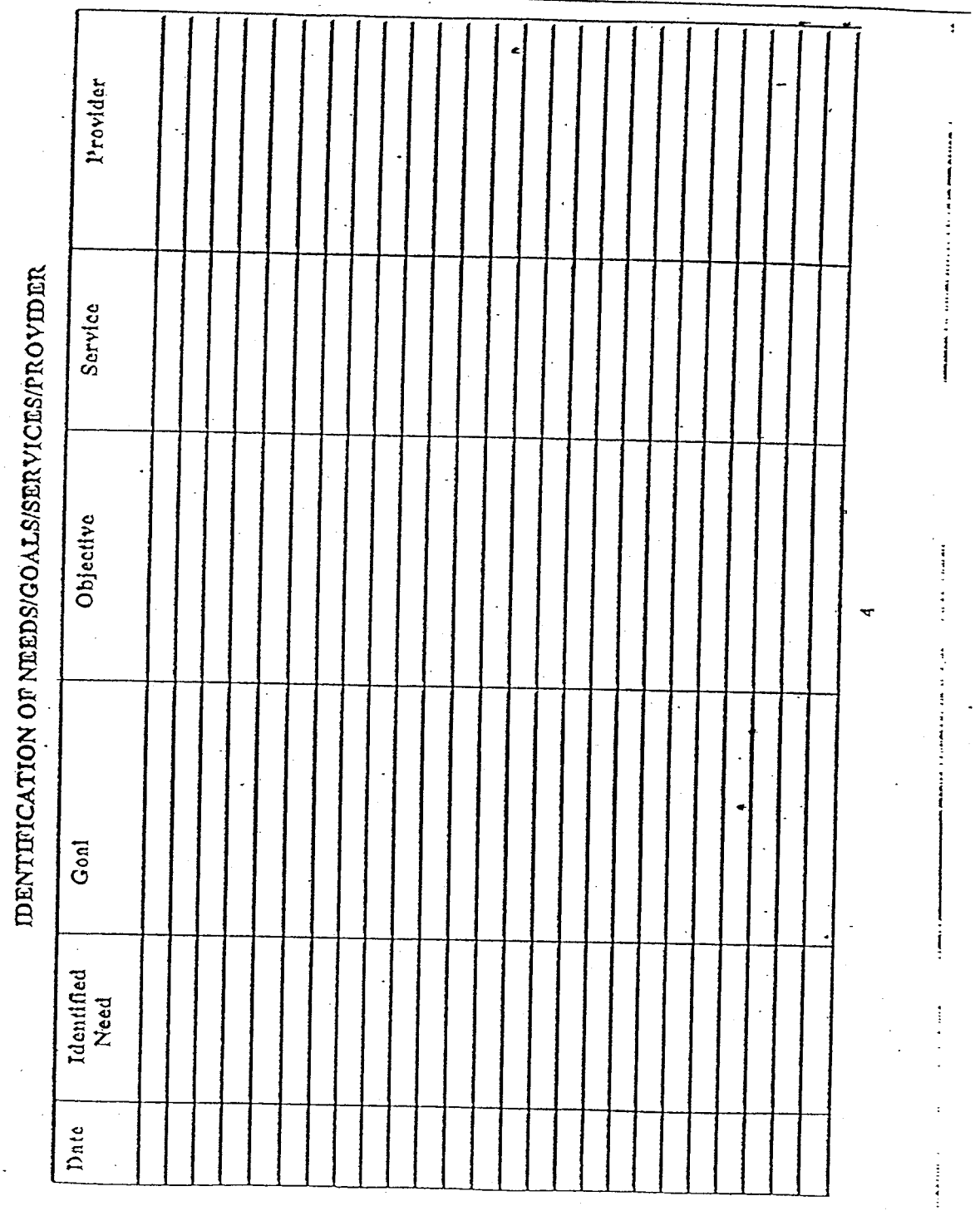
Summary of Family and Social Relationships
Current Family Members and Their Involvement: _____

Friends/Companions/Partners and Their Involvement: _____

Plan for Community Reintegration: _____

Designated Caregiver (if other than legal representative):
Name: _____ Phone #: _____
Address: _____

HOME AND COMMUNITY-BASED SERVICES PROGRAM
ACQUIRED BRAIN INJURY
PLAN OF CARE
MAP-4097



HOME AND COMMUNITY-BASED SERVICES PROGRAM
ACQUIRED BRAIN INJURY
PLAN OF CARE
MAP-4097

Provider Name & Number	Service	Units Duration/Frequency	Cost

Total Monthly Cost: _____

Persons who had input on the development of the Plan of Care:

_____ Date: _____
_____ Date: _____
_____ Date: _____

_____ Date: _____
_____ Date: _____
_____ Date: _____

The services prescribed above have been explained to me and I agree to receive these services.

_____ Date _____
Recipient/Legal Representative

_____ Date _____
Case Manager

ACQUIRED BRAIN INJURY
PLAN OF CARE MODIFICATION
MAP-4098

MAP-4098

Acquired Brain Injury
Plan of Care Modification

Effective Date of Requested Change:_____

Case Management Agency:_____

Individual's Name:_____

MAID #_____

What has happened to the individual which necessitates a plan change?

Changes Requested:

Service/Code Provider Number Frequency/Duration Cost

A. Addition_____

B. Deletion_____

C. Changes_____

Who participated in the decision-making which determined the need for plan change?

_____ _____
Case Managers Signature Date

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
REQUEST FOR EQUIPMENT FORM
MAP-95

MAP-95
(Rev. 04-88)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

REQUEST FOR EQUIPMENT FORM

RECIPIENT'S NAME _____ MAID # _____ BIRTHDATE _____
Mo Day Yr

List Other Insurance Coverage _____

Estimated Time Needed # _____ Months _____ Indefinitely _____ Permanently

Specific Equipment Item Requested: Please include Medicare codes for parts to items such as Braces, Prostheses, and Wheelchairs (if applicable). Otherwise, group parts together under Code E1399 or appropriate miscellaneous code for braces/prostheses.

PURCHASE:

Item	Code	Manufacturer's Suggested List Price (IC Items Only)	Agency's Acquisition Cost (All Items)

Trade Name/Model Number of Equipment Item (if applicable) _____

Manufacturer's Name _____

RENTAL:

If Rental is Requested, Please Specify Amount $ _____

Supplier of Equipment _____

Address _____

Date of Delivery if Equipment Item is Already Placed in Home - Date _____

Agency Name _____ Provider # _____

Authorized Signature _____

DEPARTMENT FOR COMMUNITY BASED SERVICES FORM
MAP-24B

MAP 24B

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An EqualOpportunity Employer M/F/D"

TO: _____ County Office
Department for Community Based Services

FROM: (1) _____
Department for Mental Health/Mental Retardation

DATE: (2) _____

SUBJECT: Brain Injury Waiver Admission/Discharge

(3) _____ _____ _____ _____
(last name) (first name) (mi) (social security number)

(4) _____ _____ KY _____ _____
(address) (city) (zip) (phone #)

(5) Was admitted/discharged to the Brain Injury Waiver Program on _____.
(date)

(6) The case manager is _____ _____ _____ _____
(name) (phone #) (Provider #) (cost)

(7) _____ KY _____
(address) (city) (zip)

(8) Primary Provider: _____ _____ _____ _____
(name) (phone) (provider #) (cost)

(9) _____ _____ KY _____
(address) (city) (zip)

(10) _____ _____ _____ _____
(name) (phone #) (provider #) (monthly cost)

(11) _____ _____ _____ _____
(name) (phone #) (provider #) (monthly cost)

(12) _____ _____ _____ _____
(name) (phone #) (provider #) (monthly cost)

(13) _____ _____ _____ _____
(name) (phone #) (provider #) (monthly cost)

DEPARTMENT FOR COMMUNITY BASED SERVICES INSTRUCTIONS
MAP-24B

Procedural Instructions for MAP 24B

Upon discharge of an individual from the Acquired Brain Injury Waiver Program, the case manager shall forward a MAP-24B form to the local office, Department for Community Based Services and the Department for Mental Health/Mental Retardation Services. The case manager shall complete the form through line seven (7).

This form is also to be used by the Department for Mental Health/Mental Retardation Services to notify the Department for Community Based Services when a Medicaid applicant/recipient is admitted to or discharged from the Acquired Brain Injury Waiver Program. These forms should be mailed to the local Department for Community Based Services office where the family or interested party of the applicant/recipient resides. A copy of the MAP 24B form should be mailed to the case manager.

Use the following instructions to fill in the blanks on the MAP 24B.

Line One (1): List name of Department for Mental Health/Mental Retardation staff person who completed the MAP 24B form.

Line Two(2): List the date the form was prepared.

Line Three (3): List the last name, middle initial and social security number of the recipient/applicant.

Line Four (4): List the complete address and telephone number of the recipient/applicant.

Line Five (5): Circle admitted or discharged as appropriate and list date applicant/recipient was admitted/discharged to the brain injury program. If the provider changes, submit a MAP 24B form for the discharge and another MAP 24B form for the admission.

Line Six (6): List the name, phone number, case management agency, provider number of the case manager and the monthly case management cost of the case manager.

Line Seven (7): List the complete address of the case manager.

Line Eight (8): List the name, phone number, provider number and the monthly cost of the services to be provided by the primary provider. This should be the provider with the highest anticipated monthly costs.

Line Nine (9): List the complete address of the primary provider.

Line Ten (10), Eleven (11), Twelve (12) and Thirteen (13): List the name, phone number, provider number and monthly costs for each additional provider.

REQUEST FOR KSP CONVICTION DATA ONLY EMPLOYMENT

Request is made for any Kentucky State Police record of conviction of a crime by The person identified herein. This information shall be released to:

_____

Agency Name and Address

ACKNOWLEDGMENT BY APPLICANT

I have applied for employment with the above stated agency. I am requested that the Kentucky State Police (KSP) will provide the employer with any KSP record I may have or conviction of any crime. I know that they have the right to inspect my criminal history record and to request correction of any inaccurate information. If I do not exercise that right, I agree to hold harmless the KSP and any KSP employee from any claim for damages arising from the dissemination of inaccurate information.

APPLICANT INFORMATION (PLEASE PRINT)

NAME _____
last first middle maiden

SEX _____ RACE _____ DATE OF BIRTH _____ SOC SEC NO _____

_____
signature date

_____
witness date

Instructions:

Employing agencies should ensure that all applications information is completed.

Employing agencies should forward a check or money order made payable to the Kentucky State Treasurer in the amount of $10.00 for each submitted form

RETURN FORM TO:

Kentucky State Police
Records Section
1250 Louisville Road
Frankfort KY 40601

ABI ☐

Incident Class
Class I ☐
Class II ☐
Class III ☐

INCIDENT REPORT (Part I)

IDENTIFYING INFORMATION:

MAID/SS#:_____ Name:_____

DOB:___/___/___Reporting Agency:_____ Provider #_____

Reporting Person:_____ Title:_____ Phone:_____

Case Management Provider:_____Case Manager:_____

INCIDENT INFORMATION:

Date of Incident:___/___/_____ Time:____:____AM PM

Location (where occurred):
SDP ☐ Group Home ☐ Home ☐ ☐ Respite ☐ SR ☐ Community ☐ Community Job ☐ Other_____☐

DESCRIPTION OF INCIDENT: (To be completed by staff witnessing or discovering the incident)

Who was involved? What happened? Where did it happen? Why did it happen? Action Taken?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ /___/___

Signature of Person Reporting **Title** **Date**

NOTIFICATIONS

Reported to:	Class I		Class II		Class III Fax or Phone		Class III Final Report (7 days)
Case Manager	24 hours	Date:___/___/___ Time:_____AM PM By whom:	24 hours	Date:___/___/___ Time:_____AM PM By whom:	8 hours	Date:___/___/___ Time:_____AM PM By whom:	Date:___/___/___ Time:_____AM PM By whom:
DMHMR/ BISU		N/A	10 days	Date:___/___/___ Time:_____AM PM By whom:	8 hours	Date:___/___/___ Time:_____AM PM By whom:	Date:___/___/___ Time:_____AM PM By whom:
Guardian		Date:___/___/___ Time:_____AM PM By whom:	24 hours	Date:___/___/___ Time:_____AM PM By whom:	8 hours	Date:___/___/___ Time:_____AM PM By whom:	Date:___/___/___ Time:_____AM PM By whom:
DCBS		N/A		N/A	8 hours	Date:___/___/___ Time:_____AM PM By whom:	Date:___/___/___ Time:_____AM PM By whom:
Other		Date:___/___/___ Time:_____AM PM By whom:		Date:___/___/___ Time:_____AM PM By whom:		Date:___/___/___ Time:_____AM PM By whom:	Date:___/___/___ Time:_____AM PM By whom:

Instructions for Completing Part I of Incident Report

The approved form must be used as written and not altered in any way.

Complete all blanks on the form

Check appropriate incident class

Description of Incident: the person witnessing or discovering the incident must complete this section. The incident analysis must be detailed and include all participants and their involvement in the incident. Where appropriate, individual's actions and staff response should be documented.

SUMMARY OF REPORTING REQUIREMENTS:

Who Reports:	*Reportable to:*	**Class I**	**Class II**	**Class III**
Provider Agency	Case Manager	Within 24 hours of discovery	Within 24 hours of discovery	Within 8 hours of discovery
Provider Agency	MHMR/BISU	Not reportable	Within 24 hours of discovery, followed by complete written report within 10 calendar days of discovery	Within 8 hours of discovery, followed by complete written report within 7 calendar days of discovery
Provider Agency	Guardian	Report as indicated by guardian	Within 24 hours of discovery, followed by complete written report within 10 calendar days of discovery	Within 8 hours of discovery, followed by complete written report within 7 calendar days of discovery
Provider Agency	DCBS	N/A	N/A	Within 8 hours of discovery

MAID/SS#: _____ Name: _____ Incident Date: _____

INCIDENT REPORT (Part II)
(DESIGNATING INCIDENT CODES)
(Check **ALL** That Apply)

A SUSPECTED/ALLEGED ABUSE
- ☐ 1 Emotional, Community Person to Individual
- ☐ 2 Emotional, Parent/Family to Individual
- ☐ 3 Emotional, Individual to Individual
- ☐ 4 Emotional, Staff to Individual
- ☐ 5 Physical, Community Person to Individual
- ☐ 6 Physical, Parent/Family to Individual
- ☐ 7 Physical, Individual to Individual
- ☐ 8 Physical, Staff to Individual
- ☐ 9 Sexual, Community Person to Individual
- ☐ 10 Sexual, Parent/Family to Individual
- ☐ 11 Sexual, Individual to Individual
- ☐ 12 Sexual, Staff to Individual
- ☐ 13 Verbal, Community Person to Individual
- ☐ 14 Verbal, Parent/Family to Individual
- ☐ 15 Verbal, Individual to Individual
- ☐ 16 Verbal, Staff to Individual
- ☐ 17 Unknown

B SUSPECTED/ALLEGED NEGLECT
- ☐ 1 Community Person to Individual
- ☐ 2 Parent/Family to Individual
- ☐ 3 Staff to Individual
- ☐ 4 Unknown

C SUSPECTED/ALLEGED EXPLOITATION
- ☐ 1 Community Person to Individual
- ☐ 2 Parent/Family to Individual
- ☐ 3 Individual to Individual
- ☐ 4 Staff to Individual
- ☐ 5 Unknown

D DEATH OF PERSON
- ☐ 1 Accident
- ☐ 2 Criminal Act
- ☐ 3 Illness
- ☐ 4 Natural Causes
- ☐ 5 Suicide

E RESTRAINT
- ☐ 1 Unnecessary Restraint
- ☐ 2 Emergency Chemical Restraint
- ☐ 3 Emergency Physical Restraint
- ☐ 4 Emergency Mechanical Restraint

F SEVERE BEHAVIORAL ISSUES
- ☐ 1 Sexual Contact
- ☐ 2 Threatened Suicide
- ☐ 3 Attempted Suicide
- ☐ 4 Severe Behavior Outburst
- ☐ 5 Property Damage
- ☐ 6 Self Abuse
- ☐ 7 Individual aggressed to Staff

G SERVICE SITE/RESIDENCE UNINHABITABLE
- ☐ 1 Loss of Electric
- ☐ 2 Loss of Heat
- ☐ 3 Loss of Water
- ☐ 4 Other Safety Issues

H SERVICE SITE/RESIDENTIAL FIRE
- ☐ 1 Requiring Relocation
- ☐ 2 Resulting in Personal Injury
- ☐ 3 Resulting in Property Loss

I ACT UNACCEPTABLE BY PUBLIC
- ☐ 1 Individual
- ☐ 2 Staff

J HOSPITAL VISIT/ADMISSION
- ☐ 1 Emergency Room
- ☐ 2 In-patient
- ☐ 3 Medical
- ☐ 4 Medical, Medication Therapy IV
- ☐ 5 Medical, Surgery
- ☐ 6 Psychiatric, Behavior reasons

K PERSON MISSING FROM
- ☐ 1 Structured Day Program Site
- ☐ 2 Residence
- ☐ 3 Community
- ☐ 4 Other

L ADMISSION TO NURSING FACILITY
- ☐ 1 Medical Needs
- ☐ 2 Rehabilitative Needs

M SERIOUS INJURY RESULTING IN
- ☐ 1 Cast Applied
- ☐ 2 Medical Procedure (MRI, Xray)
- ☐ 3 Medication
- ☐ 4 Referral to other Physician
- ☐ 5 Splints
- ☐ 6 Stitches/Staples
- ☐ 7 Wrapping
- ☐ 8 Other

N MEDICATION ERROR
- ☐ 1 Dose(s) Missed Entirely
- ☐ 2 Not within admin window when due
- ☐ 3 Wrong Dose Given
- ☐ 4 Wrong Medication Given
- ☐ 5 Wrong Route

O CRIMINAL ACTION AS VICTIM/PERPETRATOR
- ☐ 1 Arrested
- ☐ 2 Victim of a Crime
- ☐ 3 Other

P INJURED PART OF BODY
- ☐ 1 Abdomen
- ☐ 2 Ankle Left
- ☐ 3 Ankle Right
- ☐ 4 Anus
- ☐ 5 Arm Left
- ☐ 6 Arm Right
- ☐ 7 Back Left
- ☐ 8 Back Right
- ☐ 9 Buttocks
- ☐ 10 Chest Left
- ☐ 11 Chest Right
- ☐ 12 Chin
- ☐ 13 Collarbone
- ☐ 14 Ears
- ☐ 15 Eyes
- ☐ 16 Face
- ☐ 17 Fingers Left Hand
- ☐ 18 Fingers Right Hand
- ☐ 19 Foot Left
- ☐ 20 Foot Right
- ☐ 21 Genitals
- ☐ 22 Groin Area
- ☐ 23 Hand Left
- ☐ 24 Hand Right
- ☐ 25 Head Back
- ☐ 26 Head Front
- ☐ 27 Knee Left
- ☐ 28 Knee Right
- ☐ 29 Leg Left
- ☐ 30 Leg Right
- ☐ 31 Lips
- ☐ 32 Mouth
- ☐ 33 Neck
- ☐ 34 Nose
- ☐ 35 Rib
- ☐ 36 Shoulder Left
- ☐ 37 Shoulder Right
- ☐ 38 Teeth
- ☐ 43 Hip
- ☐ 44 Wrist Left
- ☐ 45 Wrist Right

Q CAUSE OF INJURY
- ☐ 1 Accident
- ☐ 2 Bite/Sting
- ☐ 3 Equipment Failure
- ☐ 4 Equipment Operator Error
- ☐ 5 Fall
- ☐ 6 Individual's Behavior
- ☐ 7 Lift/Transfer Error
- ☐ 8 Medical Condition
- ☐ 9 Scalding
- ☐ 10 Staff Person
- ☐ 11 Unsafe Condition, Service Site
- ☐ 12 Unsafe Condition, Home
- ☐ 13 Other

R TYPE OF INJURY/EMERGENCY CONDITIONS
- ☐ 1 No Apparent Injury
- ☐ 2 Abrasions
- ☐ 3 Allergic Reaction
- ☐ 4 Angina/Chest Pain
- ☐ 5 Aspiration
- ☐ 6 Asthma
- ☐ 7 Bedsores
- ☐ 8 Blister
- ☐ 9 Blood Clot
- ☐ 10 Bone Breaks/Fractures
- ☐ 11 Bowel Blockage
- ☐ 12 Bronchitis
- ☐ 13 Bruises/contusions
- ☐ 14 Burns
- ☐ 15 Chafed/Chapped
- ☐ 16 Choking
- ☐ 17 Communicable Disease
- ☐ 18 Concussion
- ☐ 19 Constipation
- ☐ 20 Cracked/Missing Tooth
- ☐ 21 Dehydration
- ☐ 22 Diarrhea
- ☐ 23 Dislocation
- ☐ 24 Gout
- ☐ 25 Heart Rhythm Irregularities
- ☐ 26 Hematoma
- ☐ 27 Hepatitis
- ☐ 28 High Blood Pressure
- ☐ 29 High Blood Sugar
- ☐ 30 Irritation/Rash
- ☐ 31 Laceration
- ☐ 32 Lesion
- ☐ 33 Low Blood Sugar
- ☐ 34 Malnutrition
- ☐ 35 Nausea/Vomiting
- ☐ 36 Pneumonia
- ☐ 37 Puncture
- ☐ 38 Scabies
- ☐ 39 Seizures
- ☐ 40 Significant Infection
- ☐ 41 Skin Ulcers
- ☐ 42 Soft Tissue Swelling
- ☐ 43 Spasms
- ☐ 44 Sprains
- ☐ 45 Strains
- ☐ 46 Stroke
- ☐ 47 Sunburn
- ☐ 48 Swallowing Objects

MAID/SS#: _____ Name: _____ Incident Date: _____

INCIDENT REPORT PART III (cont)
(DESIGNATING INCIDENT CODES)
(Check **ALL** That Apply)

J HOSPITAL VISIT/ADMISSION (cont)
- ☐ 7 Psychiatric, Medication Adjustment
- ☐ 8 Psychiatric, Suicidal
- ☐ 9 Psychiatric, Threat to Others

P INJURED PART OF BODY (cont)
- ☐ 39 Throat
- ☐ 40 Toes Left
- ☐ 41 Toes Right
- ☐ 42 Other

R TYPE OF INJURY/EMERGENCY CONDITIONS (cont)
- ☐ 49 Ulcers
- ☐ 50 Upper Respiratory Infection
- ☐ 51 Urinary Tract Infection
- ☐ 52 Other

Instructions for Completing Part II of Incident Report (Designating Incident Codes)

Check all areas that apply to the incident.

Do not write in changes to items checked. If item doesn't apply as stated on the form, do not check it.

Most incidents will require multiple checks to fully describe the incident.

If "unknown" or "other" is checked in any area, then details should be provided in the narrative.

INCIDENT REPORT (PART III)
(SUPERVISOR/CASE MANAGER REVIEW)

INCIDENT FOLLOW-UP:

Analysis of incident, staff action taken and incident follow-up:_____

_____

_____

_____

_____

How can this incident be avoided in the future? (who made this decision)_____

_____

_____

_____

_____

Staff training needs identified (include training plan and who's responsible):_____

_____

_____

_____

_____

Individual support needs identified:_____

_____

_____

_____

_____

Current Status:_____

_____

_____

Submitted by:_____ Title:_____ Date:___/___/__

Additional Signatures:

_____ Title: Case Manager Date:___/___/____

_____ Title:_____ Date:___/___/____

_____ Title:_____ Date:___/___/____

Instructions for Completing Part III of Incident Report (Supervisor/Case Manager Review)

The information in this section summarizes the results of follow-up needed for Class I incidents or the investigations conducted for Class II and Class III incidents.

The follow-up should include a critique of staff response and action taken. This critique should analyze what occurred before and after the incident to help determine if staff responded appropriately.

Also included should be a plan to ensure that the incident does not occur again as well as stating who was involved in developing this plan. Preferably actual or planned dates of completion would be included.

Staff training needs identified as a result of incident follow-up/investigation, along with a training plan, would be included in this section.

Also included should be a statement about the current situation of the individual involved in the incident.

Person completing the follow-up from the provider agency shall sign along with the Case Manager and other relevant parties.